INFORMATION

Control of Cancer Quackery

THE 1959 CALIFORNIA LEGISLATURE, in Senate Bill No. 194, gave the Department of Public Health responsibility for the enforcement of a program to protect the public from unorthodox or unproven methods for the diagnosis, treatment or cure of cancer.

To assist and advise the department, this antiquackery law authorized gubernatorial appointment of a 15-member Cancer Advisory Council consisting of nine physicians and surgeons, two representatives from cancer research institutes, three others who are not physicians and surgeons and the Director of the Department of Public Health. At the first meeting in January, 1960, John W. Cline, M.D., was elected chairman of the council for the ensuing year.

The legislation requires anyone offering an agent for the diagnosis or treatment of cancer to furnish samples, on demand, for investigation or testing by the department. When it is established by scientific and legal processes that this agent is misrepresented or ineffective, the department may order that its use be discontinued. If this order is not complied with, under certain other circumstances, the department may prosecute.

Within the Department of Public Health a Cancer Diagnosis and Therapy Evaluation Unit has been established to furnish staff service to the council and to carry on the antiquackery program. This unit is staffed by K. F. Ernst, M.D., as head, Mr. J. Richard Jackson as field representative and a secretary. During the year this unit has been in existence, one clinic and one remedy have been investigated and further action by the Attorney General is now awaited.

The department has received pledges of support from the deans of all the schools of medicine in California, some individual physicians and other scientists, State Boards of Examiners and other groups. Support of all practicing physicians and of all agencies in the state is needed and is earnestly solicited. This support may take any or all of the following forms:

(a) Whenever patients who have had treatment with unproven methods come to the attention of any physician, society, bureau or other agency, the Cancer Unit in the Department of Public Health should be notified and preliminary arrangements made for an interview. The patients should be asked to retain any letters, advertising or medicines they may have received in connection with the treatment.

(b) Historical notes to record methods of diagnosis, claims and details of treatment, name of the treatment and of the clinic or individual offering it and the cost of the treatment should be made while still fresh in the patient's mind. If it is suspected that the diagnosis of cancer is false, diagnostic studies to confirm the diagnosis or to show that it is incorrect should be performed.

(c) Objective findings for comparison with those before treatment, if known by the physician or stated by the patient, should be recorded.

(d) Autopsies on patients who die after treatment with unproven methods should be encouraged.

(e) Notification may be made by mail to the Cancer Unit, State Department of Public Health, 2151 Berkeley Way, Berkeley 4, or by telephone to THornwall 3-7900, Extension 321.

Factual or opinion testimony by physicians or other scientists regarding physical findings or the efficacy of a given remedy is of tremendous value when a case is being considered before a hearing officer.

$317,000 Settlement in Malpractice Case

ON DECEMBER 22, 1960, there was announced perhaps the largest settlement made in a malpractice case. After three weeks of trial, the case against a surgeon, two anesthesiologists and a hospital was settled for $317,000. (*Carvainis v. Montefiore Hospital for Chronic Diseases,* Supreme Court, N. Y. County, Index No. 11907-1957, Calendar No. 21461.)

The plaintiff was a 49-year-old housewife, the mother of four children. She entered the defendant hospital April 4, 1956, for a vaginoplasty. A spinal anesthesia was administered. Because the patient was decidedly obese, the lithotomy position was indicated. Evidence was produced at the trial along the following lines:

An excessive dose of anesthetic agent was administered; an unexplained very high level of insertion at T-10 was made. The operating table did not function until after it had been pushed, jerked, jostled and vigorously shaken in order to put it in the Fowler's position and to release the drop leaf. Each and every element would cause the anesthetic level to rise to an abnormally and undesired high level.

Respiratory difficulties arose, with a secondary cardiac arrest, and a thoractomy with heart massage was done. Although the heart responded after two